

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-027771

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 99

Primary Registration District No. 4168

Registrar's No. 41

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

FILED AUG 6 1963

1. PLACE OF DEATH

a. COUNTY

DeKalb

b. CITY (If outside corporate limits, give TOWNSHIP only)  
OR TOWN Maysville

Length of stay in lb  
34 Yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
a. STATE Mo b. COUNTY DeKalb

c. CITY OR TOWN Maysville

c. FULL NAME OF (If NOT in hospital, give location)  
HOSPITAL OR INSTITUTION

Inside Limits  
Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location)

Reside on Farm  
Yes ☐ No ☐

3. NAME OF DECEASED  
(Type or print)

First FLORA

Middle

Last MOLLOY

4. DATE OF DEATH Month Day Year  
July 8 1963

5. SEX  
Female

6. COLOR OR RACE  
White

7. Married ☒ Never Married ☐  
Widowed ☐ Divorced ☐

8. DATE OF BIRTH  
12/7-1892

9. AGE (last birthday)  
70

IF UNDER 1 YEAR  
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)  
Milan, Missouri

12. CITIZEN OF WHAT COUNTRY  
U.S.

13a. FATHER'S NAME

Austin Coon

13b. MOTHER'S MAIDEN NAME

Mamie Brasnith

14. NAME OF HUSBAND OR WIFE

Elmer Molloy

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes, give war or dates of serv)

No

16. SOCIAL SECURITY NO.

17. INFORMANT  
Elmer Molloy Maysville Mo.

Address

18. CAUSE OF DEATH (Enter only one cause per line)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Hypostatic Pneumonia

INTERVAL BETWEEN ONSET AND DEATH

2 days

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

Chronic Myocarditis

15 yrs

DUE TO (c)

Chronic Arteriosclerosis

25 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED?  
YES ☐ NO ☐

20a. ACCIDENT SUICIDE HOMICIDE  
☐ ☐ ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour Month, Day, Year  
10:30 a.m. July 8, 1963

20d. INJURY OCCURRED WHILE AT WORK ☐  
NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from  
Death occurred at

July 8, 1963 10:30 AM and last saw her alive on 7/7/63

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

Maysville Missouri

22c. DATE SIGNED

7/9/63

23a. BURIAL, CREMATION, REMOVAL (Specify)  
Burial

23b. DATE

July 10 1963

23c. NAME OF CEMETERY OR CREMATORY

Oak Lawn

23d. LOCATION (City, town, or county)

Maysville Missouri

24. FUNERAL DIRECTOR

ADDRESS

Pilcher Funeral Home, Maysville Mo

25. DATE RECD. BY LOCAL REG

7-30-63

26. REGISTRAR'S SIGNATURE

Herbie C. Davidson

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

INSTEAD OF

DATE AMENDED

BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

SEP 6 1963

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

**G. T. Pilcher**

Licensed Embalmer No. 3960

P. O. Address Mayesville Missouri

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.